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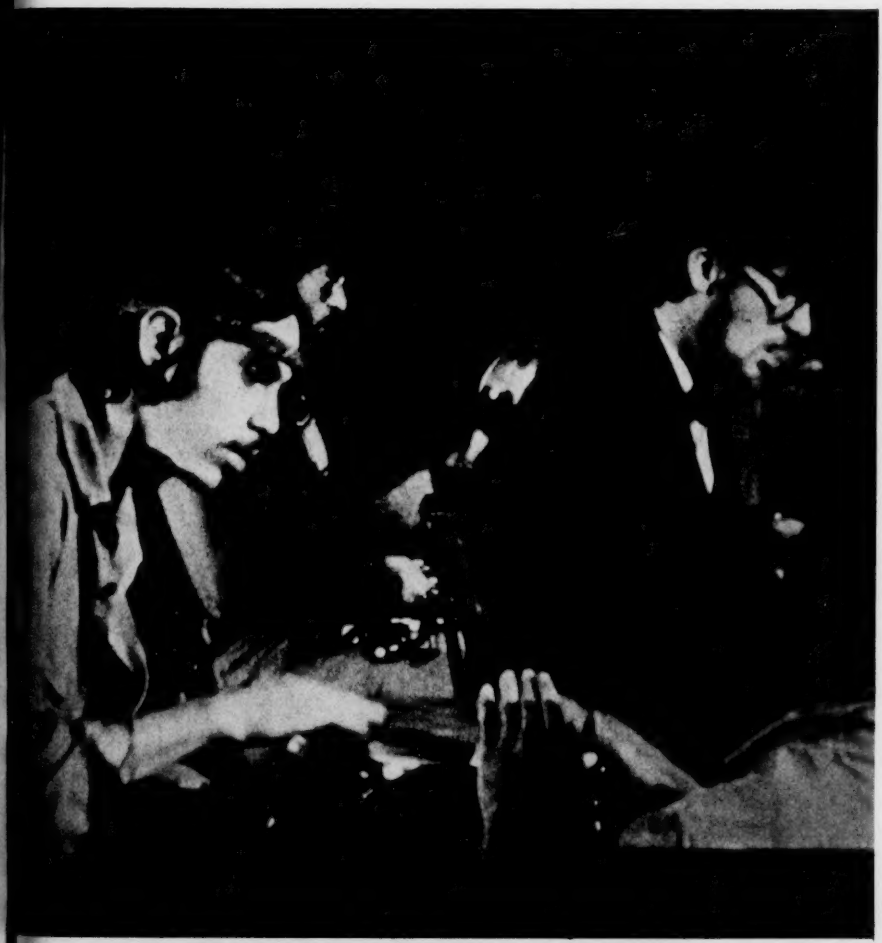

cover story

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A Social-Therapeutic Jazz Club in England

CHARLES WINICK and MARIANN A. WINICK

How can the activities and interests of young people that are frowned upon be made the basis for social-therapeutic activity? One answer has been provided by a unique organization in England that uses "rhythm and blues" and jazz music to help young people in achieving more mature social functioning while upgrading their interests in music. The vehicle is the Eel Pie Island Jazz Club. So far as its members are concerned it is just another jazz club, but its therapeutic goal was basic to its creation. The Club was founded in 1956 by Arthur Chisnall, a sociologist, who conceived of it as an open therapeutic community.

The Club is on an Island in the Thames, reachable by a 300-meter walk from the center of Twickenham and requiring passage on a footbridge. Not only is it open only at night, but its separation is reinforced by a location on what newspapers call the "Isle of Rhythm" and the membership card, which is called a "Passport to Eelpiland." The travel metaphor is sustained by the four-penny toll which must be paid to get over the bridge. The Club is reached by following a narrow, winding road. The Club is in a pub that serves beer, and there is also a bar in the club room itself.

Members enter the Club by a hallway, in which several of its staff members are usually standing and chatting. Most of the active members are easily recognized by staff, but those few who are not immediately identifiable are asked to present their membership cards. Non-members can apply for membership, which costs six shillings. Members are required to pay three and a half shillings for each admission.

Members find few chairs on which to sit. Most of them stand and listen to the music being played at the far end of the dimly lit, smoky hall. The nature of the music and the performers vary: Wednesday is devoted to heavy beat "rhythm and blues," Saturday is for "trad" or conservative jazz, and Sunday's music is a more sophisticated "rhythm and blues." Younger members are likely to come on Wednesdays, older ones on Saturdays. Attendance is best on Sundays.

The members' age range is from 18 to the late 20's, and they are almost equally divided between males and females. Except on Saturdays, there is little dancing. Members usually stand around and chat.

Although no one is assigned to move around inside the building, there is continual circulation by the staff. There is also steady verbal communication between staff and members. How is therapy accomplished? Workers at the Club convey an accepting and non-judgmental attitude. A new member can come as frequently or infrequently as he wishes, so that the Club is minimally threatening. The Island's rakish reputation contributes to its appeal for many youngsters.

The staff regulates the proportion of the kinds of members, and some therapeutic changes in attitudes, goals, and social behavior appear to result from the interaction among the different groups. Communication is so central to the therapeutic rationale that the only dimensions on which members are classified is in terms of

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their being part of a high-, medium-, or low-communication culture. Other forces making for therapy are conversations initiated by the staff, the music itself, vocational help, and identification with the Club's founder.

Contact Among Membership Groups

Leaders have concluded that an optimal therapeutic mix is provided by 55–65 percent high communicators, 15–25 percent medium communicators, and 10–20 percent low communicators. Personnel selling tickets can estimate the communication level on the basis of costume, appearance, and speech patterns, and use their knowledge to keep the desired ratio.

High communicators are often students and tend to be upward mobiles from the upper-lower middle class. The medium communication group is more practical, less interested in theory, and includes many apprentices and students. The low communication group includes the more orthodox people, often from the working class.

Bringing together such disparate groups under conditions of relaxation and social equality appears to have a therapeutic effect on the low and medium communicators as a result of their identification with more upward and effectively functioning members. The high communicators may be helped therapeutically and can enjoy themselves while acting as change agents.

The low and medium communicators are exposed to the role models provided by the high communicators. The atmosphere of free discussion and other participation in activities seems to help people to become more articulate and some members are encouraged to express ideas that had been latent. If it is felt that too many low communicators are active, there may be a delay in their being processed for membership, and the staff becomes stricter in requiring presentation of membership cards.

Between 20 and 40 new members join each night. If the person seeking admission appears a doubtful case, e.g., low communication but showing initiative, he may be admitted for the evening. Membership is so important to its participants that they provide a tacit wall of resistance to any rowdies who might drift in, or against regular members who may "act out." One way of enhancing the importance is that a lost membership card is not replaced. A member who has given his card to a non-member is likely to have his card confiscated. This procedure is known to many members, so that the card tends to assume more than its monetary value.

The Club never advertises. Word of mouth is the only way by which the activities are disseminated and contributes to its members' enthusiasm and identification with the place.

Inasmuch as there are over 28,000 members, there is a continuing opportunity for contacts with persons from other social strata. At any one time there are 200–300 members who come every night for up to 18 months. Another 500–600 members come once a week, having previously been among those who came every night. Many members are absorbed into the Club atmosphere at an age when they may feel very much out of society. What began as compulsive attendance leads to more relaxed attitudes, firmer self-concepts, and to experimentation with other social environments and situations.

There tends to be a period in which the member leaves because "the Club is only for kids." After about a year, he usually feels that he can come back and "take it or leave it." One benefit of having members who have gone

through this stage is that their visible confidence rubs off on the newer members. Self confidence is probably the single most important attribute of the person who has participated in the Club successfully. His self concept improves in terms of interpersonal relations, clothing, and taste in music.

Change takes place over an extended period of time. Approximately six months are required for a low communicator to become ego involved, and two years of participation may be required to move from low to high communication levels.

The Club's reputation for good music is so well established that performers are eager to play there. Members realize the superiority of their Club's music when they compare it with what is offered at other clubs. There is never any attempt at didactic explanation, although discussion is spontaneously generated. The continual upgrading of musical taste that occurs is cumulative.

The music helps to quell any impulses toward "acting out." There is no rowdyism, and "incidents" occur only when someone has had too much to drink. Young people who behave violently ("rockers") would more likely be found at neon-lit clubs that feature less sophisticated music.

Vocational Help

Group reinforcement is enhanced by scholarships to colleges and other institutions that have been made available from Club income. If money is needed for a purpose of which the members approve, an effort will be made to raise it. Financial assistance is handled informally.

A related function, also informal, is vocational guidance by a staff person chatting with a member during a break, or while the music is playing. Such guidance is requested by the members and may be more productive than would a formal session. Information on vocational guidance tends to be passed from member to member, often circuitously.

The Founder

For many "unattached" young people, one appeal of the Club has been its independence of the establishment social agencies and their perception of Mr. Chisnall as a person who is an ally, if not himself a rebel. He is not only successful outside the Establishment, but conveys a positive feeling of self-hood. Even though the Club's success is related to its founder's charismatic personality, the success of Synanon in setting up branches in States other than California suggests that an innovative group-therapeutic format can be adapted by leaders other than its founder.

Some Extensions of the Club Concept

The Club's success suggests the possibility that in the United States, where jazz is so acceptable, especially to high-risk delinquency groups, an analogous activity might be successful. With our interest in new and imaginative approaches to social therapy and programs for youth, some modification of the Club's approach would seem to be worth trying, especially in college towns.

Physicians' Use of Mood-Altering Drugs: A 20-Year Follow-up Report

GEORGE E. VAILLANT, JANE R. BRIGHTON, and CHARLES MCARTHUR

Abuse of alcohol and mood-altering drugs may be the most common sign of psychiatric illness in physicians. There is also good evidence that in physicians in general, not just those who seek psychiatric help, narcotic abuse is more frequent than in the population at large.

Since most physicians are neither narcotic addicts nor admitted to psychiatric hospitals, the literature fails to answer two questions. In comparison to nonphysicians, do physicians tend to overuse drugs? If they do overuse drugs, do they use alcohol and tobacco less? Since physicians form a group selected by intellectual proficiency and occupational perseverance, their use of drugs and alcohol ought to be compared with that of a nonmedical group that shares these characteristics. To obtain an accurate picture of drug abuse, subjects must be studied over long periods.

In the late 1930's a study was undertaken of several consecutive sophomore classes at a liberal arts college. To be accepted into the study, the student had to be considered by the college health service, dean's office, and dormitory staff to be free of physical, emotional and academic difficulties. Of 268 men, 10 dropped out early, the others have been followed until death or to the present. Of the sample 46 became physicians; one died in 1955. The remaining 45 constitute the present sample.

All were followed by questionnaires mailed every two years and by occasional personal interview. The men participated conscientiously and loyally.

The data used here were the written answers to the following questions:

Cigarettes per day in 1949, 1953, 1957, 1964, and 1967. (In the same years similar information about pipe and cigar smoking was collected.)

Use of alcohol in 1949, 1953, 1957, 1964, and 1967.

Trouble controlling drinking in 1953, 1964, and 1967.

Increased use of tobacco and alcohol under stress in 1954 and 1967.

Whether they took "any medicines or drugs" in 1949, 1957, and 1964, and if they used "sedatives" in 1951 or "tranquilizers," "sedatives," or "stimulants" in 1966–67.

Ninety controls were obtained by selection of the two nonphysicians alphabetically adjacent to each physician.

In terms of age, father's income on college entrance, private-school preparation, scholastic and mathematical aptitude on college entrance examinations, and problems during infancy, the men were comparable. In terms of relative psychologic soundness ratings the doctors were not different from the controls. In terms of the conscientiousness with which questionnaires were returned, the doctors were slightly more faithful.

Follow-up information on the 135 men was nearly complete. Prospective data were available for at least four out of the five intervals (1949, 1953, 1957, 1964, and 1967) for 89 percent of the men and for at least three of the five intervals for 97 percent.

Twenty-five years after graduation, the occupational success and physical

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health of the participants were superior to that of classmates not in the study. Sixty-nine percent of the physicians graduated from five medical schools (Columbia, Harvard, Rochester, Pennsylvania, and Johns Hopkins); 78 percent passed their specialty boards, and almost half have held the rank of assistant clinical professor or above at a medical school. Occupational success of the controls seemed comparable.

In comparing the use of mood-altering drugs (sedatives, tranquilizers and stimulants) by the two groups, "abuse" indicates use of sedatives beyond the limits usually prescribed in medical practice. The "regular" use of sedatives by physicians was significantly greater than that by the controls. "Regular-use" refers to participants who took sleeping pills more than once a month for several months, frequent use of amphetamines (for reasons other than weight control) or daily use of prescription tranquilizers for more than a month. Twice as many physicians as controls took tranquilizers, but the difference was not statistically significant.

Only one man, a physician, experienced social and occupational impairment because of the use of pills. Four physicians and one control combined barbiturate use with use of amphetamines, but not on a daily basis. Fifty-seven percent of the controls, but only 20 percent of the physicans, were recorded as taking not more than one mood-altering pill a year. The increased use of mood-altering drugs by physicians appeared to be due to self-prescription.

There was no difference in the drinking patterns between the two groups. Over the years an increasing number of men from both groups reported either "heavy drinking"—3 percent at 28, 7 percent at 32, 9 percent at 36, 12 percent at 43, and 16 percent at 46 years of age.

Over the years the percentage of smokers remained about 60 percent. Although the number of cigar or pipe smokers increased, there was a rise and then a drop in the number of heavy cigarette smokers. Physicians included fewer heavy smokers and also fewer nonsmokers. The smoking habits of the 135 men do not differ from those of their unselected classmates. It is noteworthy that the subjects as sophomores smoked more than sophomores at the same college 20 years later.

Three doctors were occupationally incapacitated by use of alcohol or drugs, and each spent about a year in the hospital. One physician required frequent short hospitalizations for alcohol but was able to keep his spree drinking and the practice of medicine separate. Another was unemployed for a decade, and the occupational efficiency of a third was impaired for five years. At last contact all three were practicing medicine and not misusing drugs or alcohol.

Abuse of alcohol, and perhaps of mood-altering drugs, by these men is less than that by 45-year-old American males in general. This report focuses on the peak use of drugs and alcohol over a 20-year period in a group of men who have been unusually conscientious in reporting such use. But if doctors selected for health in college have less of a problem with alcohol than the general population, they do take pharmacologic agents that affect the central nervous system more than matched controls do. In short, doctors at the healthy as well as the pathologic end of the continuum show a relative excess of drug use.

Psychiatric study of physician addicts suggests that increased avail-

ability of drugs may not be enough to explain doctors' vulnerability to drug and alcohol misuse. Psychologically, physicians who are addicts resemble people who obtain narcotics illegally more closely than they do nonaddicted physicians. Doctors give "overwork" as the most common explanation of why they take narcotics. But this explanation hides other needs. Medicine is hard work for anyone, but it is harder work for those who use the profession vicariously to give solace to others rather than themselves. In our study none of the three physicians hospitalized for drugs or alcohol was literally overworked. But all three had experienced a consistent lack of support and concern from their parents that distinguished them from other study members.

Second, physicians learn to dissociate themselves from danger to be able to cope with it. Every physician must engender in himself the belief that "it can't happen to me." Such a credo helps patients but creates difficulty for the doctor's own physician. An illustration of the denial of distress in self-medicating physicians was a doctor who consulted one of us because of addiction to meperidine. He stated that he was not suicidal, not depressed, and asked to attend to his own cure. Yet this was a physician who wept during the interview, and who injected meperidine into his thigh with unsterile technic while driving on a superhighway.

To mitigate the hazards of drug use in physicians, several steps can be taken. The physicians of doctors should recognize that their patient's tendency to deny illness will make a diagnosis difficult; the patient's virtue of not troubling his doctor may lead to the wish to self-prescribe; and, the patient's willingness to care for others may conceal a greater than average need to be given to. The physicians of doctors should be alert to depression in their patients and inquire directly about self-medication. Urine tests for opiates and blood tests for barbiturates may be revealing in any physician who represents a diagnostic enigma.

A frank attitude is critical for State medical societies. In seeking supervision for addicted physicians, one of us was assured by two medical societies that the problem was too small to merit attention. In California and New York, where medical societies and boards of medical examiners have confronted the question frankly, drug abuse appears to be a problem worthy of notice.

Finally, medical schools must assume responsibility for teaching students that they represent a high-risk population for drug abuse. No physician should write a prescription for himself for a drug that will make him feel better, sleep better, or work better. This will not be easy for the student to hear; he will argue that his instructor is over-cautious. But in our group of 45 physicians, preselected for psychologic soundness, self-medication with drugs or alcohol was the cause of one-third of the total time that they spent in the hospital.

Users and Nonusers of Marihuana: Some Attitudinal and Behavioral Correlates

FRANCIS W. KING

The few recent, respectable, and replicable researches on drug usage to date have made but a slight dent in our ignorance. The present paper may be viewed as a modest, interim report limited to students' drug of choice, marihuana.

The focus is upon a few variables that might be related to whether or not a student smoked marihuana. Some interest is also directed toward sampling attitudes that nonusers might have regarding the use of marihuana. A "user" is defined as an individual who has smoked marihuana on one or more occasions.

In 1968, each undergraduate at Dartmouth College received one of several questionnaires pertaining to marihuana; in some forms there were questions pertaining to LSD. The present report is based upon some of the findings from one questionnaire which was sent to a random sample of 775 students; 66.8 percent responded. In the responding population, 130 had used marihuana one or more times.

On two items referring to the banning of cigarettes and to fornication, the users are different from the nonusers, but the difference is not very impressive. The total respondent population takes a "liberal" view, with the marihuana smokers showing a somewhat higher frequency of that view. The difference between the two groups regarding opposition to parietal hours does seem to be an impressive one, suggesting a more generalized opposition to external control on the part of the users. Parietal regulation is considered by many to be less personally private and to be more of a community matter. There is a tendency for the more frequent smokers of marihuana to be more opposed to these regulations.

Another group of items relates to attitudes toward the use of external agents for including tension relief and relaxation. There are no differences between the two groups concerning attitudes toward the tension-reducing value of cigarettes and alcohol. The marihuana users, however, value that drug as a tension reducer. They do not appear to be characterized by a generalized view of external agents as relaxing; rather their attitudes appear to be specific to marihuana. Those more experienced in the use of marihuana tend to rate more highly the relaxing and tension-reducing effects of the drug. These findings are consonant with the notion that there is a learning phase involved in the enjoyment of marihuana.

The next group of items has to do with attitudes of users and nonusers in relation to the legal status of marihuana. The distribution of users' responses in relation to the number of times marihuana has been smoked indicates that positive and permissive attitudes increase in number and intensity as a function of the frequency of use.

It is hardly astonishing to find differences between users and nonusers on such items—although the magnitude of the differences is of a high order. Of more interest are the shifts in percentage of responses of nonusers as a function of the conditions stated in the questions. Among the

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nonusers, 21 percent either took the neutral position or failed to answer the question regarding the legalization of marihuana. Although 45 percent of the nonuser respondents favor legalization, only about 36 percent of such respondents stated their opposition to legalization. Those nonusers who take a permissive attitude toward the smoking of marihuana by others constitute essentially the same percentage as those who favor legalization. However, given a lifting of the legal restrictions, an additional 10 percent express a permissive attitude toward the use of marihuana by others.

Less than one-third of the nonusers feel there is a possibility that a situation might arise in which they might try marihuana. It looks as though the possibility of being caught smoking marihuana is not a great deterrent, perhaps because it is easy to arrange a situation which minimizes the realistic possibilites of being apprehended. (If it were otherwise, our courts and prisons would be clogged with offenders.) Thirty-one percent of the nonusers admit the possibility of trying marihuana under present conditions of illegality. Given the legalization of the drug, the number of nonusers who might try it increases by less than 10 percent.

Another group of items included questions that asked the students to indicate how well informed they felt they were on the physiological and psychological effects of marihuana and asked them to estimate the potential physiological and psychological dangers. The differences between the two groups are markedly significant. Those who had smoked only one or two times distributed their responses in a manner somewhat similar to the nonusers. With increasing use, the responses indicate that the users feel better and better informed on the physiological and psychological effects; this holds somewhat more for the psychological than for the physiological ones.

Belief in the potentially harmful effects of marihuana in a physiological sense is practically nonexistent among the marihuana smokers. Of the nonusers, only 3 percent took the most extreme position regarding physiological dangers; an additional 9 percent selected the next most harmful point on the scale.

Both groups view marihuana as possessing more danger psychologically. Nearly three-fifths of the nonusers see the drug as potentially dangerous psychologically. Among the 55 students who had smoked on more than five occasions, only one student perceived any degree of physiological harmfulness; in that same group, only five students perceived any degree of psychological danger.

The final group of items was directed toward behavorial or situational variables. Although there were no significant differences between users and nonusers in their attitudes toward the tension-reducing value of cigarettes and alcohol, a significantly larger proportion of users smoke cigarettes.

There is a tendency for more users than nonusers to drink alcoholic beverages. Among the users, there were no teetotalers in the group who had smoked marihuana between one and 15 times. Five of the 34 heavier users (who had smoked marihuana on more than 15 occasions) reported that they did not use alcoholic beverages. It would be of interest to learn whether these students had never used alcohol or whether they had turned to marihuana and had given up alcohol. Of the 15 heaviest users of marihuana (smoked on more than 50 occasions) 87 percent are either nondrinkers or light to moderate drinkers. This is in marked con-

trast to those who have smoked from one to 10 times; in this group, nearly 40 percent are regular or heavy drinkers or both. There is suggestive evidence that for some students marihuana may be a substitute for the country's preferred drug.

Although the data confirm the notion that attempts to obtain alcohol while under age are hardly a rarity, the marihuana users have been more active in this pastime. Thus, the reports of behavior of the subjects are consistent with their attitudes toward external control. Since one-quarter of the sample used marihuana and since few users appeared to make a secret of it, one should not be surprised that 88 percent of the nonuser group has known someone who has used marihuana. Less than half of that number has been in the presence of someone who was "under the influence of" marihuana. Of the total sample, 57 percent have had the opportunity to try marihuana; less than half has tried it. This leaves, then, 43 percent of the nonuser group who have had the opportunity to try marihuana but who, for whatever reasons, have elected not to do so.

Note: In the original article the spelling "marijuana" was used. The spelling was changed to "marihuana" in conformance with the style manual of the Government Printing Office.

Hypothalamic-Pituitary-Adrenal Axis in Methadone-Treated Heroin Addicts

PAUL CUSHMAN, JR., BERTRAND BORDIER, and JAMES G. HILTON

The physiological implications of sustained administration of narcotics in man are poorly understood. Little is known regarding influences of these drugs on the endocrine system, particularly the hypothalamic-adrenal (HPA) axis. Establishment of the functional integrity of the HPA axis in man receiving narcotic agents is of great clinical and pharmacological importance.

The recent development of the methadone regimen, in which methadone is administered apparently as a substitute for heroin, has resulted in the transformation of a number of New York City addicts into more reliable subjects, who became available for study.

Methadone-treated subjects were studied in two groups: Group I were 16 males hospitalized for acute withdrawal from heroin and the institution of methadone. They were free of manifest renal, hepatic, and endocrine diseases by standard clinical criteria. Their studies were carried out in the fourth or fifth week off heroin, and they were not known to be taking any other drugs.

Group II were ambulatory outpatient methadone subjects, male, 23–45 years, without clinical evidence of endocrine, liver, or kidney disease, who had been receiving 80–100 milligrams of oral methadone daily for an average of 7.8 months.

Heroin addicts were ambulatory males, 23–52 years, all of whom stated they arrived for study shortly after a heroin injection.

Controls were eight male hospital personnel volunteers. All were free of clinically evident renal, hepatic, and endocrine disease. None was taking any drugs.

The metyrapone responses of Group I were tested on Day 4, or the day after the completion of administration of 750 milligrams four times for six doses, in which the excretion of 17-ketogenic (KGS) steroids in the 24-hour urine was employed as the criterion of responsiveness. ACTH gel was administered on Day 5 as 40 U twice daily. The completeness of the serial five-daily, 24-hour urine collections was checked by daily urinary creatine determinations. In Group I, plasma samples were drawn at 4:00 p.m. on Day 1, and at 8:00–9:00 a.m. on Day 2, for 17-OH-corticosteroid determinations in order to appraise the nycthemeral variation of HPA activity.

Insulin hypoglycemia was performed in the "fasting" state by the i.v. administration of 0.1 or 0.15 U/kilogram.

The 24-hour excretion of 17-KS and 17-KGS was normal in all subjects where it was measured, except one patient, whose values were borderline. The increment in 17-KGS after metyrapone in 14 of 15 instances was at least 40 percent above the control value. The increase in 17-KGS excretion after ACTH was two–four times the control values in all cases. These subjects had normal resting adrenal cortical activity, normal adrenal responsiveness to exogenous ACTH, and normal responses to metyrapone.

The 8:00–9:00 a.m. plasma corticosteroid concentrations were within the normal range for this laboratory

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but the 4:00 p.m. values were high. It was possible to demonstrate a normal diurnal variation in only 37.5 percent. In six others, the 4:00 p.m. values actually exceeded the corresponding 9:00 a.m. controls, or a reversal of the normal nycthemeral pattern.

The results of the insulin hypoglycemia studies in Group II show that after a satisfactory fall in blood sugar (51 percent of the initial value at 30 minutes or less), in eight of nine subjects a rise in plasma corticosteroids occurred at 60 to 120 minutes. These responses were normal by comparison with a group of normal healthy controls.

The results of insulin hypoglycemia studies in the eight heroin addicts not receiving methadone show a satisfactory fall in blood sugar was achieved in all but one. The plasma 17-OH-cs prior to insulin administration ranged from 2.7 to 30.2 micrograms/100 milliliters. All subjects showed a rise in the 17-OH-cs after insulin. Although the mean increase was not different from the controls, there were three subjects with maximal increases over the baseline of less than 8.9, the lowest observed in normal subjects. Two of these probably did not have an adequate hypoglycemia, since their blood sugars and percent of the fasting sugar at 30 minutes were the highest in this group.

Neither methadone nor morphine interfered with the phenylhydrazine-H_2SO_4 reaction since recoveries averaged 97.8 and 100.4 percent of hydrocortisone. Similar concentrations did not interfere with the m-dinitro-benzene-KOH reaction, since recoveries averaged 94.7 percent of dehydroisoandrosterone.

The data confirm the clinical impression of normal adrenal cortical function in the methadone-treated addict in that the resting plasma and urinary steroids were normal.

Pituitary ACTH secretion is regulated by a neuroendocrine system in which changes in corticotophin releasing factor (CRF) determine ACTH release. This system can be operationally considered in three interrelated categories; i.e., stress, feedback, and nycthemeral periodicity. Although the complete anatomical loci of these influences have not been established, it is widely held that the median eminence of the hypothalamus acts as the final common pathways of secretion of CRF. It is likely that the stress and feedback exert their principal actions at this site; the nycthemeral periodicity mechanism appears to be more diffusely represented in the central nervous system involving the limbic and reticular activating systems.

In the patients with hypothalamic diseases, these neuroendocrine functions may be normal, or impaired together, but they may at times be dissociated.

In the methadone-treated addict, examination of the feedback mechanisms regulating HPA activity by means of metyrapone showed no impairment since normal increases in 17-KGS were obtained in all subjects. The stress mechanisms governing HPA axis were normal in eight or nine subjects since increases in plasma 17-OH-corticosteroids followed insulin hypoglycemia. These findings suggest that methadone-treated heroin addicts may not be potential hypopituitary subjects.

The data obtained in the heroin addicts not receiving methadone support the conclusion that the stress mechanisms regulated in HPA activity are operative. These studies do not demonstrate a significant heroin or methadone propensity to block hypothalamic function of either the feed-

back or stress mechanisms regulating HPA activity. In confirmation of the clinical impression, these patients would not appear to be particularly susceptible to overt or occult pituitary-adrenal insufficiency.

On the other hand, the studies of the diurnal variation of plasma corticosteroids in the methadone-treated addicts yielded different results. A normal or near-normal value was demonstrable in only six of 16.

It is possible that methadone or heroin may interfere with the normal nycthemeral periodicity, leading to a flattening or reversal of the usual pattern without modifying the feedback or stress mechanisms. An analogous situation seems to have been encountered in the patients with hypothalamic diseases, who may exhibit a loss of periodicity without necessarily an impairment of their stress or feedback mechanisms regulating HPA axis activity. Further studies will be required to establish this possibility.

Anxiety over the study protocol or venipunctures is unlikely. Anxiety was not clinically evident in these patients who had been hospitalized for over three weeks. Their 9:00 a.m. plasma values for 17-OH-cs were normal. They were well habituated to venipunctures as the result of their administration of heroin. Another possibility was that sufficient liver disease was present to modify the rate and pattern of corticosteroid metabolism and turnover. This possibility would appear unlikely in view of the normal clinical status of the patients, laboratory evidence of normal liver function, and the normal plasma and urinary steroid metabolites in both the resting and ACTH (endogenous and exogenous)-stimulated states. An alteration in cortisol transport in plasma with an increase in bound cortisol could account for the high afternoon levels, without the necessity of postulating any disturbance in hypothalamic function. This possibility would appear to be unlikely since the change was evident in only some of the subjects.

The Structure of Psychological Processes in Relation to Cerebral Organization

A. R. Luria, E. G. Simernitskaya, and B. Tubylevich

In modern psychology, it is accepted that each kind of mental activity has a distinct psychological structure and is effected through the joint activity of discrete cortical zones.

Research has established that the accomplishment of certain movements is based on a strict system of afferent syntheses. But there are well-known facts in the clinic which do not accord with these conceptions. The accomplishment of one and the same kind of activity sometimes proves inaccessible to a patient with a local brain lesion, while sometimes it presents no difficulty whatsoever. An example is a patient who was asked to utter the word "No" and who finally said: "No, doctor, I am absolutely unable to say 'no'." Every clinician will recall other instances. All attempts to explain such facts were reduced to the statement that the activity now bears a "voluntary," now an "involuntary" character, or is included now in "abstract," now in "concrete" behavior. Such attempts present a description of the phenomena rather than their explanation.

We assume that with the gradual development of each kind of psychological process, the latter changes its psychological structure and is effected through the activity of a different system of cortical zones. Precisely this assumption explains the facts described.

At one time this assumption was advanced with regard to the ontogenetic development of mental processes.

Observing the development of memorization in children, Soviet psychologists found that with the transition from preschool to school age, the direct impression of traces is replaced by mediated memorization, which involves coding of the material memorized and thus receives an absolutely different psychological structure. Investigating the development of memory in identical and fraternal twins, one of us established that with increasing age, not only the structure of memory changes, but also its relation to the genotype; whereas the elementary (direct) form of memorization exhibits a highly genotypical character, with the transition to complex (mediated) forms of memorization, it loses its genotypically determined character and comes to depend on external conditions. This fact indicates that, as development proceeds, the inner nature of the psychological processes involves a radical change.

We believe that the functional development of a variety of psychological activities is governed by this principle. There is evidence suggesting that, as a result of frequent repetition, psychological operations not only become more rapid and cease to require conscious control, but change their psychological structure and come to be organized by some other (i.e. differently located) system of cerebral control.

The facts which confirm it boil down to the following: a local brain lesion disrupting the normal course of a certain psychological process may leave unaffected the course of more consolidated automatized operations; this leads to the conclusion that well-automatized forms of mental activity are based on quite a different cerebral control system.

Condensed with permission from *Neuropsychologia*, 8(1): 13–19, 1970.

Numerous observations of this kind were carried out on patients with local brain lesions manifesting disturbances in the process of writing. This process includes an acoustic analysis of the sounds (phonemes) constituting the word, elements of uttering the word (kinesthetic analysis), which clarifies its phonetic composition, and a spatial analysis of the elements of the latter which represents the given sound graphically and may therefore be disturbed by local lesions of the left temporal, left-post-central and left parieto-occipital regions of the cortex. However, observation showed that the recognition of familiar written words may remain intact even in those cases in which the reading of unfamiliar words or writing them from dictation is deranged. We cannot forget a case in which a highly cultured woman with a vascular lesion involving the speech zones of the left hemisphere was unable to write a single word from dictation, but could easily cope with the same task, when asked to write quickly, "without a moment's thought." Apparently, such rapid writing of a familiar word made unnecessary the acoustic analysis of its composition and allowed the expression of the intact kinesthetic stereotype.

Our example with the writing process applies to other forms of activity. The clinic knows numerous facts of the following kind: patients who are unable to repeat a word (or to pronounce it at will) easily utter this word when it is used in the context of an assimilated and well automatized phrase; some patients who unsuccessfully attempt to read a relatively rare word easily recognize "by sight" a habitual "ideogram"; patients who cannot successfully accomplish the operations of addition and subtraction easily cope with a well-automatized operation of multiplication, etc.

These facts show that a highly automatized activity (which results from "functional development") proves to be intact when a local brain lesion makes the accomplishment of a less highly automatized activity impossible.

All this makes highly probable our proposition, according to which a psychological operation changes not only its structure, but also its cerebral organization in the course of its functional development.

There is no doubt that the neuropsychological method—the method of investigating patients with local brain lesions—may make a contribution to the further analysis of the changes which psychological processes undergo in the course of their establishment or exercise and of the concomitant changes in their underlying cerebral organization.

Splitting the Normal Brain with Reaction Time

R. A. Filbey and M. S. Gazzaniga

For years, it was supposed that the corpus callosum served no important function. During the last two decades, "split-brain" studies have shown that the callosum is responsible for relaying sensory and motor information present in the right hemisphere over to the left and vice versa. With it intact, one can describe all visual events to the left or right of fixation, but with it sectioned, only those events falling into the right visual field can be described. An important task is to study the system intact, with the aim of coming to an understanding of the logic and nature of the information-transmission mechanism.

Experiment 1—The left hemisphere is usually responsible for speech. Information presented directly to the left hemisphere ought to be reported sooner than that presented to the right hemisphere. The difference in reaction time should reflect the time needed to transmit the information across the callosum.

Eight right-handed coeds were instructed, following the onset of a buzzer, to fixate a specific point in the visual field. Following a flash, they were to make a verbal response indicating the presence or absence of a dot as quickly as possible and without making an error. The dot was presented either one degree to the right or left of fixation. Half the subjects were instructed to respond "yes" to a dot and "no" to a blank. The remaining were to respond "yes" to a blank and "no" to a dot.

When a callosal transmission is necessary for either making the discrimination (blank presentation) or responding appropriately (dot appearing to the left of fixation), reaction times are slower by about 30 milliseconds. This difference might be due to more peripheral perceptual variables (or to the right cortex simply not being as fast at this task).

Experiment 2—Eight right-handed subjects were instructed to give a manual response of moving a lever to the right or left, depending on the stimulus. Half were instructed to move it to the right if they saw a dot and to the left if the field was blank. The remaining were to move the lever to the right following a blank and to the left for a dot. Manual responses to both right and left dots appear to be about equal, while those to blank fields average about 30 milliseconds slower.

The experiment using a motor response differs from the one using a verbal response in that, in the former, both hemispheres have access to the response without using the callosum, while in the latter, only the left hemisphere has access to the response. A callosal transmission is necessary to determine whether or not the entire field was blank. If the results of the first experiment are due to peripheral perceptual variables or to right cortex inferiority in the task, the results of the second experiment should be identical to those of the first. They are not.

Now it remains to be discovered whether this callosal transmission time increases with the complexity of the discrimination. The answer would give evidence as to the amount of processing that each side of the cortex does, i.e., whether the callosal transmission is some sort of "go/no-go" message or an elaborate readout of raw visual information.

Condensed with permission from *Psychonomic Science*, 17(6):335–336, 1969.

The Cognitive Control of Behavior: A Comparison of Systematic Desensitization and Hypnotically Induced "Directed Experience" Techniques

Don Gibbons, Leslie Kilbourne, Alan Saunders, and Cheryl Castles

The purpose of this investigation was to test the relative merits of Systematic Desensitization (SD) and "Directed Experience" hypnosis (DET) in reducing test anxiety.

Twenty-seven student volunteers from an introductory psychology class participated. Test anxiety was measured with the Mandler-Sarason Test Anxiety Questionnaire. Subjects in the DET group were given three one-hour sessions during a two-week period. During each session, a deep hypnotic trance was invoked, utilizing the sleep induction method. At each session, the experimenter induced states of relaxation, happiness, and tranquility. The subject was then told that he was taking a test. The situation differed for each trance, and the subject was told that the test was important and that some serious decision concerning his future depended on the results.

The subject was presented selected items of the verbal section of an IQ, achievement, or aptitude test and allowed to respond. The experimenter interpreted for the subject how well he felt and how effectively he performed. The experimenter then suggested post-hypnotic amnesia and awoke the subject.

The SD subjects were given two one-hour sessions in deep muscle relaxation. Each team constructed a 10–15 item hierarchy of testing situations in terms of their anxiety-provoking potential. At the beginning of each session, deep muscle relaxation was instated in the subject, and he was asked to visualize scenes which corresponded to the ranked order of the hierarchy beginning with the lowest item. During the subsequent three hours of desensitization, each subject proceeded up his hierarchy at a rate determined by his anxiety reaction to each item.

The results demonstrated that DET was more effective. This is due to the fact that, first, DET utilizes control of the situation to induce pleasant affect directly, as opposed to deep muscle relaxation used in SD. Through hypnosis the degree of emotional attachment to the test-taking situation involved the totality of the organism as opposed to the selected response elements of SD. Second, DET goes directly to a maximally anxiety-arousing situation whereas SD uses a hierarchy. Third, DET controls the subject's psychological environment, so the subject actually believes he is experiencing the situation suggested. Fourth, DET provides an interpretation of the experience for the subject.

This study indicates that hypnosis may be used in a way which allows the subject to experience something which he normally does not experience, and that this experience will then be a determinant of change. If this is possible, reduction of test anxiety is only a starting point for a wide range of therapeutic applications.

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Zen and Psychotherapy

BINGHAM DAI

Although Zen, the teaching of a Chinese Buddhist sect, is generally thought of as a form of religious mysticism, it may be considered as a system of psychotherapy. Zen and psychotherapy share a common objective to enable man to enjoy the benefits of society and culture without losing his innate spontaneity and to live a full and creative life without being hampered by undue anxiety.

The nature of human nature—Perhaps the most authoritative and concise statement of the Zen theory of human nature is the following verse of Hui-neng (638–713 A.D.):

The mind is the Bodhi tree.
The body is the mirror stand.
The mirror is originally clean and pure.
Where can it be stained by dust?

My understanding of this verse is that human nature is good and that the original mind of man is perceptive, spontaneous, and flexible; its response to stimuli is appropriate and adaptive, provided it is not "attached" to, and unduly influenced by, egotistic cravings, passions, and delusions. This original mind of man is called Buddha nature.

This theory may sound strange to some psychotherapists. Actually few of us do not practice with the assumption that the homeostatic principle operating in the "inner environment" of man will somehow function equally well in his psychological environment.

Even Freud worked most consistently on this assumption; namely, if we can help remove the obstacles in the patient's way so that he can say freely what comes to his mind, the chances are that something in him will come up with the right answers to the problems of his life. Whatever one may choose to call this something, there is no denying that it is the patient himself who knows and who informs the therapist, even though he often does not know that he knows.

The genesis of human suffering—The Platform Sutra had this to say:

> . . . "no-thought" has been instituted as the main doctrine, "non-form" as the substance, and non-attachment as the foundation . . . ." "Non-form" means to be detached from form even when associated with it. "No-thought" means not to be carried away by thought in the process of thinking. Non-attachment is the original nature of man.

This passage means that man's original spontaneity and adaptability is often stunted or ruined by personal and cultural compulsives. While participation in society and culture is essential for the development of the individual personality, these personal and cultural compulsives often breed shortsightedness, narrowmindedness, bigotry, intolerance, unhealthy inhibitions, unfounded fears, and irrational hostilities, and pathological behaviors.

In both Zen and psychotherapy the most important source of human suffering has been found to be man's excessive ego-preoccupation. In order to restore man's original intuitive capacity and his adaptive flexibility, Zen emphasizes the need for liberation from the compulsive cravings of the ego and points to the regenerating freedom and creativity of what a Japanese Zennist, Koji Sato, has aptly called the "egoless ego."

Similarly, psychotherapy has found narcissism, the morbid love of self, to be the most important source of neurotic anxiety and the capacity to love,

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the most essential source of emotional health and strength.

Methods used to alleviate human suffering and to restore spontaneity—The principal method used by Zen to free man's mind and to restore its spontaneity and flexibility is meditation. "Zen" means meditation in Sanskrit (dhyana). There are different kinds of meditation and what was taught by the founders of the Zen sect in China was different from those practiced by the other Buddhist sects. In fact, compared with the latter, it can almost be said to be not meditation at all.

In practice, the early Chinese Zennists did not do away with meditation altogether. What was discarded was the Indian way of restricting meditation by ritualistic procedures and its conceiving of meditation and insight as separate processes. What was advocated was that the Zen student should learn to accept all thoughts that come to his mind but to be detached from them at the same time, so that his spontaneity and straightforwardness may function freely. This is known as the practice of "no-thought."

The psychotherapeutic method that is comparable to meditation is free association. For what is meditation, if it is not a kind of marathon free association minus the presence of an analyst? There are differences. The Zen monk during meditation usually faces his problems alone, while the patient thinking aloud is engaged in some form of communication with his therapist. Zen and psychotherapy differ in their approach to biologic needs and ego strivings. When a Zen monk is troubled by sexual or aggressive impulses, he is taught to suppress or to renounce them, whereas the patient is often encouraged to express them in words and to find the ways to satisfy them. Which way is more healthy can be an interesting subject for study.

Other methods used by the Zen masters that are different from psychotherapy are the use of precepts and personal examples and the form of questions and answers, involving the use of *koans*.

Since *koans* are puzzling, it may be worthwhile to mention one or two that are commonly used. A monk asked, "What is the meaning of Bodhidharma's coming from the West?" The master replied, "The cypress tree in the courtyard." The same question put before another master was answered, "The teeth of the board grew hair." What the masters tried to convey to, or to awaken in, the pupil is described as:

> . . . the Zen Master . . . was merely making a plain and straightforward statement of what he saw and felt at the moment the question was put. Plain, yet marvelous, this feeling is the most cherished keystone of Zen—sometimes described as the *tang hsia i nien* or instantaneous thought. . . .

Tang hsia i nien means the first thought that comes to mind, which is also what free association means. Their differences in method notwithstanding, Zen and psychotherapy share a common goal: to cultivate the ability to respond to any situation immediately and spontaneously without the interference of undue anxiety.

Perhaps the most spectacular method used in Zen is the systematic induction of a trance or a trance-like state by the use of such devices as the setting of a time limit for the attainment of enlightenment—varying from five to seven days—and the monotonous repetition of a sound, such as *Mu*. Both devices can produce a psychological state, in which the individual loses his self-awareness and in which he identifies himself with his surroundings, resulting in a momentary exhilarating feeling of

oneness with Nature and with his fellow human beings.

Use of such artificial means as a shortcut to enlightenment is not an essential part of Zen. It was not known in the first 400 years of the Zen movement in China. Even the use of the *koan* did not become prevalent until the latter Sung Dynasty in the eleventh century. Many Zen devotees prefer the less dramatic method of "serene reflection."

When enlightenment comes, it is usually the result of a process, which follows the stages of discovery in science or religion. First, a period of sustained intellectual activity—in the case of the monks, many years of searching and meditation; then a period of relaxation in which the sustained activity is suspended and attention is drawn to something different—in the case of the monks, listening to the temple bell, for example, or receiving a surprise blow from the Zen master; and finally, the sudden emergence of insight or enlightenment, when it is least expected.

Although psychotherapy does not claim anything as dramatic as the *satori* experience, it is not unfamiliar with the phenomenon of sudden insights. And when they come to a patient, they also follow the same stages of discovery as mentioned above.

There is another similarity between Zen and psychotherapy. This has to do with the effectiveness or validity of the *satori* experience. Many Chinese Zen masters have taught that the *satori* experience alone is not sufficient: it has to be translated into everyday living. They make a distinction between *chien* or insight and *hsing* or practice. The latter concept is equivalent to "working through" in psychotherapy. The effects of the *satori* experience on the everyday behavior of the Zen pupils can be a fascinating area of study.

The goal of Zen and psychotherapy—The goal of the Zen discipline is a man who thinks, feels, and acts with the degree of objectivity, spontaneity, freedom, and compassion that can come only from having transcended his personal and cultural compulsives and from feeling at one with all sentient beings and with Nature. Such a Zen man has been described in various ways. One Zen master calls him "the man of no rank," meaning not being attached to anything external. Another describes him as a man who eats when he is hungry and drinks when he is thirsty; no anxiety interferes with his functioning freely as a biosocial being.

This applies equally well to the results of effective psychotherapy; inevitably there is a decrease of ego-preoccupation, accompanied by a corresponding increase of genuine interest in other people.

Ways in which Zen and psychotherapy can learn from each other.—In the course of my experience as a psychotherapist in this culture, I have come to the conclusion that the greatest obstacle to a patient's functioning freely and creatively is his excessive ego-preoccupation and morbid competitiveness. This has led me to think that Zen's concept of selflessness is not just a religious or philosophical ideal, but a practical goal for psychotherapy. Imagine how free a man would be, if he could appreciate and apply the message of the famous verse of an ancient Zen master:

While alive,
Be a deadman,
Thoroughly dead,
and act as you will
and all is good.

Meditation in a modified form can be used to supplement psychotherapy. My experience indicates that a patient can profit from spending 15 minutes a day on meditation or self-

examination. It seems a good way to consolidate the gains made during therapy and to continue the process of self-discovery after therapy. The Zen practice of "no-thought" should be even more useful, especially to those who have the problem of impulse control and who take themselves and their ego-extensions too seriously; the result could be a degree of detachment in the midst of involvement that is the characteristic of a free spirit.

The most important lesson psychotherapy can learn from Zen is its teaching about the original nature of man. We may think of man's original mind as his immense capacity for intuitive insight and for appropriate action, which, alas! is too often stunted by learned fears and inhibitions. To tap, to release, and to utilize this potentiality should be the main objective of therapeutic endeavor. This can be accomplished by placing emphasis on the patient's intuitive insights not on the therapist's theoretical preoccupations. The patient's intuitive insights show themselves in the following forms: his initial reaction to a given life situation in the past, which he has ignored or suppressed because of anxiety; his initial immediate reaction to a given life situation at present, which he hesitates to utilize or to carry through because of anxiety; the first thought or feeling that comes to his awareness in response to a given stimulus in the therapeutic situation, which he has failed to mention; his sudden realizations regarding his attitudes and feeling toward a given life situation; and other relatively better known forms of self-revelation, such as the patient's non-verbal behavior in the therapeutic setting, his fantasies and, most important, his dreams. To make full and consistent use of such indices of the patient's intuitive insight may be called the intuitional approach to psychotherapy.

The intuitional approach has at least three advantages: it will reduce resistance, shorten the time for therapy, and enhance the patient's self-esteem as well as his capacity for genuine independence. For he is constantly reminded by this approach that he is the leading partner in the therapeutic endeavor and that whatever progress he is making is largely due to his own effort.

Is There An Ultraconscious Beyond the Unconscious?

STANLEY R. DEAN

The term "ultraconsciousness" proposed here refers to a suprarational, suprasensory level of mentation whose existence is known under a variety of terms: *nirvana* of Buddhism; *satori* of Zen; *samedhi* of Yoga; *unio mystica* of Catholicism; *shema* of Cabbalism; and Existentialism's *kairos*. As science annihilates space and accelerates communication between the West and the East, the possibility of rediscovering ancient truths recurs with increasing frequency.

My interest in the "ultraconscious" is that of an "eclectically-oriented" observer who had an opportunity to see some of the attendant phenomena and to make a film of the Zen-Buddhist ritual. This discussion is not an endorsement but merely a plea that science should seek an explanation and a common denominator for what has so far been regarded as inexplicable.

Zen is used as an example of the attainment of "ultraconsciousness" merely because I had an opportunity to observe it. "Zen" is a Japanese word which refers to a high state of consciousness in which man finds union with the "Ultimate Reality" of the universe. This state is called *satori;* the closest English equivalent is "enlightenment," Zen and *satori* are not only enlightenment but also the way to its attainment.

The concept of "no mind" is basic to Zen. It is achieved by intense concentration, controlled breathing, fixation of gaze, the disciplined environment of a Zen institute, and the inspiration of a Zen master.

The important thing is that when the mind stops thinking it does not stop being, for then the mind becomes automatically inundated with a flood of awareness, intuition, cosmic identification, and rapture that transcends description and transforms the entire personality at its ultimate peak, although in some only partial attainment may occur.

What significance does this have for the scientist, physician, psychiatrist? It may mean that systematic research on the ultraconscious may provide an important addition to our psychotherapeutic armamentarium, not only because its attainment exerts an enabling influence on the mind but of its ability to bring about freedom from mental and physical suffering.

Although most people have never experienced the summit of the ultraconscious, questioning might well elicit the information that many have had flashes and *formes frustes*. These might become more or less standardized and available for study and therapy instead of being confined to religious or regional areas.

Clinical practice also provides ample scope for observation and awareness. A first step would be merely to ask patients if they had any ultraconscious experience and encourage them to talk about it. Many psychiatrists might be amazed at the material which would be elicited. And if the resulting pharmacological and clinical material were collected, pooled, and collated, the data might represent the initial breakthrough to understanding of this hitherto inscrutable subject.

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Mental Health in a Community Health Program

BLAINE E. MCLAUGHLIN

The community mental health movement came about because of disenchantment with the State hospital system. In North Dakota, investigations made the medical public realize that State mental hospitals had fallen far behind private psychiatric and private hospitals in the handling of the mentally ill patient. Against this frame of reference the community mental health program in North Dakota was started, using techniques which had proved successful in private hospitals. Applying techniques which have proved successful on a limited basis to a broad area is full of danger. There had been no community mental health centers in North Dakota until 1964. The first problem was persuading the public that mental health should be a community thing. The churches, medical societies, and teachers' groups were of fundamental importance. One thing that is better in rural areas is the public interest of physicians. This was a great help. We needed the support of the local people to have them understand that this was not surplanting private practice, but would act as a complement to private practice.

We have perhaps one of the most conservative medical societies. There was grave doubt about the use of public funds on a non-fee basis for the care of the mentally ill. We bridged this gap through education, through the understanding that the physician was in charge, and he could utilize the mental health center or not utilize it.

At our center, all referrals come from physicians. If a person wanders in from the street, or is sent by a clergyman or psychologist, he is sent to his family doctor for a thorough review. The patient is comprehensively reviewed by his family physician within the first few months of therapy. This procedure was instituted so we could identify ourselves with the family doctor, and the belief that the doctor could be of help to us. The churches were important. We were able to get 12 percent of the voters to approve this plan by having the applications available in the church.

Our clinic has finished its third year. In attendance are two full-time psychiatrists, three psychologists, four social workers, and a Protestant and a Catholic consultant. There is a consultant nurse and occupational therapy personnel. Full-time participation in a public health program has been accepted.

The Potential Neurotic Depressive Patient

One thing we discovered was the amount of depression in a rural area. Our experience suggests that over 50 percent of the patients are depressive, and most recover fairly quickly. A plea is made to the general practitioner to consider depression during the initial examination. When the patient is depressed in a psychotic sense, the general practitioner can recognize it. These patients are usually referred quickly to the hospital.

The patients we are concerned about are those who are beginning to be depressed. Seventy-five percent are anxious patients who are beginning to wear out from handling their anxiety, that is, exhibiting chronic anxious or emotional fatigue. Perhaps the other 25 percent are schizoid individuals who are overwhelmed by environmental problems. The general

Condensed with permission from *Clinical Medicine*, 77(1):21–24 passim, 1970.

practitioner has to make a distinction. The schizoid individual is probably best handled in the general practitioner's office. The psychiatrist might help in terms of diagnostic sharpening and in terms of social service. But the current feeling is that the schizoid should be kept in the environment and as carefully as possible kept moving and doing something. Once patients are in the State hospital, the job of getting them back into the community is much more difficult. It behooves us all to develop programs which can utilize the limited capacity of schizoid patients in the community.

The patients who come to the general practitioner with anxiety and anxiety equivalents, such as somatic distress, are potentially all neurotic depressives. The general practitioner must try to reverse this type of depression as quickly as possible and institute proper treatment.

The idea should not be overlooked that depression is very common in the young. Depression, under stress, in the youth of the nation is a tremendous problem. Elderly people are not free from depression either. Depression in the aged is a serious thing, and is the most important thing for the general practitioners to recognize.

Treatment of Depression

What are the mechanisms of treatment for neurotic depression? In the psychiatric field, it is felt that there are two major mechanisms which the doctor should use. The first is to allow the patient to slip back into a simpler and more convenient or easier frame of reference. The physician is the person to say to his patient, "Don't do these things. Let me be responsible for your not doing these things which seem to be such a problem." The patient who says, "I cannot think of going once more to that church meeting and standing up before that Board of Elders," thinks of the physician as someone who can help him get away from this overwhelming experience.

The general practitioner can treat at least 75 percent of the incipient depressions in his patients by the use of mild drugs and by establishing a solid doctor-patient relationship. The patient must not get the feeling that the drugs are the magic answer; he should be encouraged to talk with the physician for 15 or 20 minutes at least two or three times a month. The physician can do some social service counseling, or perhaps can alter the patient's environment in some way which may be helpful. The mental health clinic, the minister, the employer, the family, and even the Lion's or other Clubs should be utilized. The community must be encouraged to help this person to be accepted on a level that he can manage. We think 75 percent of those patients exhibiting potentially neurotic depressive symptoms can be managed successfully by general practitioners. The other 25 percent should be referred to the psychiatrist.

General Practitioner and Community Psychiatry

AENGUS O'ROURKE

It has been estimated in Great Britain that at least half a million people are out of work at any one time with psychiatric complaints. The extent of psychiatric illness in Ireland is probably higher than in England. Ireland has the highest psychiatric admission rate in the world. How many cases of psychiatric illness the general practitioner sees is not known. Estimates range from 10–50 percent of patients seen in a working day.

The 1959 Mental Health Act in England proposed that the large responsibility for the treatment of the mentally sick should be transferred to those working in the community. How well equipped a general practitioner is to deal with psychiatric and emotional problems is doubtful. During my undergraduate career, training in psychiatry was, to say the least, sketchy. Little importance was attached to it and many consultants in other specialties made derogatory remarks about their colleagues in psychiatry. This position does not appear to have altered.

Doctors in general practice know how important it is to have a good training in psychiatry. There is little doubt that psychiatry and the behavioral sciences should have equal emphasis with the morphological sciences in the undergraduate curriculum.

The future of general practice lies in the establishment of groups of doctors working together in community and supported by the relevant ancillary staff. Essentially this complex of community medical workers would accept responsibility for psychiatric patients in the community and would have psychiatric nurses, social workers, etc. committed to the community complex. Essential to this plan would be the closest possible communication between the psychiatric services and a general practitioner. All these interdependent workers would have to meet during their working day. The community concept would also have to be enlarged to include other interested disciplines—sociologists, educationalists, the law, and voluntary bodies.

Take the alcoholic and consider the services he may need:

A psychiatric hospital for drying-out process.
General practitioner, psychiatrist plus psychiatric nurse or social worker for the subsequent support of the patient.
Voluntary organization, e.g., A.A. or Church bodies.
Surveillance of the family by a social worker.

Then think of all the secondary people that may be involved:

The law; possibly the patient has committed some crime.
Home assistance to support the patient's home structure.
The patient's employer; to maintain his job opportunity.
The educator who recognizes the necessity for special remedial treatment of the alcoholic's children.
Supportive help for the wife; to help her cope with the social burden.

If even one member of the alcoholic patient's family becomes a psychiatric casualty, he may cost the State about £30,000 in his lifetime. Many families partially burdened with psychiatric illness become total casualties: a catastrophe arising from a lack of support at the crucial moment.

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Alcohol, Amines, and Alkaloids: A Possible Biochemical Basis for Alcohol Addiction

VIRGINIA E. DAVIS and MICHAEL J. WALSH

No form of physical dependence is more prevalent than that produced by alcohol. No substances have a greater capability of producing physical dependence than the narcotic alkaloids. The temporal and proportional differences involved in the development of alcohol addiction and narcotic addiction have contributed to concealing the possible identity of these phenomena.

We offer a hypothesis for a biochemical explanation of the similarities that are characteristic of the addictions produced by these two distinct molecular entities. Biotransformation of a drug (alcohol) to its active metabolite (acetaldehyde) induces alterations in the metabolism of a neuroamine (dopamine) and produces aberrant metabolites having unique pharmacological activity (alkaloids). The metabolism of ethanol is essential for the activation of a pathway available to this neurotransmitter which may be normally inoperative. This metabolic aberration could then lead to the endogenous production of addictive compounds.

To test this hypothesis we incubated rat brainstem homogenates with dopamine and 100 milligrams of tissue. Additions of nicotinamide-adenine dinucleotide, ethanol, or acetaldehyde were made in a volume of one milliliter at the expense of the phosphate buffer.

The effect of cofactor (nicotinamide-adenine dinucleotide) ethanol, and acetaldehyde on the metabolism of dopamine and on the relative formation of tetrahydropapaveroline was determined.

In the absence of exogenous cofactor, tetrahydropapaveroline represents the major catabolite of dopamine in liver and brain in vitro. When nicotinamide-adenine dinucleotide is added to incubation mixtures, tetrahydropapaveroline formation in liver homogenates is abolished. Although tetrahydropapaveroline production is decreased in the presence of nicotinamide-adenine dinucleotide, this alkaloid still remains the predominant metabolite of dopamine in brainstem homogenates, most probably because of the limited aldehyde-oxidizing capacity of brain. Ethanol and its metabolite acetaldehyde, enhance the synthesis of tetrahydropapaveroline in brainstem. Acetaldehyde in concentrations ranging from 0.5 to 2.0 millimole per liter produced incremental increases in the formation of this tetrahydroisoquinoline alkaloid. Enhanced formation of tetrahydropapaveroline was caused by inhibition of dihydroxyphenylacetic acid formation and diversion of the aldehyde to the condensation pathway. The effect of ethanol in inhibiting formation of the acid implies the presence of brain alcohol dehydrogenase for its conversion to acetaldehyde, the active inhibitor. Results of initial experiments indicate that the latter step in the hypothesis (tetrahydropapaveroline conversion to morphine-like alkaloids) may likewise occur. Intravenous administration of tetrahydropapaveroline-C^{14} to rats resulted in biotransformation of this compound.

These data support the concept that alcoholism is a true addiction which may involve specific biochemical events leading to the formation of the morphine-type alkaloids.

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Sex-Role Stereotypes and Clinical Judgments of Mental Health

INGE K. BROVERMAN, DONALD M. BROVERMAN, FRANK E. CLARKSON, PAUL S. ROSENKRANTZ, and SUSAN R. VOGEL

Evidence of the existence of sex-role stereotypes is abundantly present. And stereotypically masculine traits are more often perceived as socially desirable than are attributes which are stereotypically feminine. It seems reasonable to expect that clinicians will maintain parallel distinctions in their concepts of what is healthy or pathological when considering men versus women. Particular behaviors and characteristics may be thought indicative of pathology in members of one sex, but not in members of the opposite sex. We suggest that a double standard of health exists wherein ideal concepts of health for a mature adult, sex unspecified, are meant primarily for men, less so for women.

Seventy-nine clinically trained psychologists, psychiatrists, or social workers (46 men, 33 women) served as subjects.

We have developed a Stereotype Questionnaire of 122 bipolar items each of which describes, with an adjective or a short phrase, a particular behavior trait or characteristic such as:

Very aggressive—Not at all aggressive
Doesn't hide emotions at all—Always hides emotions

One pole of each item can be characterized as typically masculine, the other as typically feminine.

The clinicians were given the questionnaire with one of three sets of instructions. The "male" instructions stated "think of normal, adult men and then indicate on each item the pole to which a mature, healthy, socially competent adult man would be closer." The "female" instructions stated "describe a mature, healthy, socially competent adult women." With the "adult" instructions, the subjects were asked to describe a "healthy, mature, socially competent adult person."

Only the stereotypic items which reflect consensual distinctions between men and women, as perceived by lay people were analyzed. Two types of scores were developed: "agreement" scores and "health" scores.

The agreement scores consisted of the proportion of subjects on that pole of each item which was marked by the majority of the subjects. Three agreement scores for each item were computed: a "masculinity agreement score" based on subjects receiving the "male" instructions, a "femininity agreement score" and an "adult agreement score" derived from the subjects receiving the "female" and "adult" instructions, respectively.

The health scores are based on the assumption that the pole which the majority of the clinicians consider to be healthy for an adult, independent of sex, reflects an ideal standard of health. Two health scores were computed for each of the stereotypic items: a "masculinity health score" from subjects with "male" instructions and a "femininity health score" from subjects with "female" instructions.

The results indicate that high agreement exists among clinicians as to the attributes characterizing healthy adult men, healthy adult women, and healthy adults, sex u-

Condensed with permission from the *Journal of Consulting and Clinical Psychology*, 34(1):1–7, 1970.

specified. The results also support the hypotheses that clinicians have different concepts of health for men and women and these differences parallel the sex-role stereotypes in our society.

The clinicians' concept of a healthy, mature man do not differ from their concepts of a healthy adult. The clinicians' concepts of a mature healthy woman differ significantly from their adult health concepts.

Speculation about the reasons for and the effects of this double standard seems appropriate. Men and women do differ biologically, and these differences appear to be reflected behaviorally, with each sex being more effective in certain behaviors. We know of no evidence indicating that these biologically based behaviors are the basis of the attributes stereotypically attributed to men and to women. Even if biological factors did contribute to the formation of the sex-role stereotypes, enormous overlap exists between the sexes with respect to such traits as logical ability, objectivity, independence, etc. Variation within each sex is great.

More likely, the double standard for men and women stems from the clinicians' acceptance of an "adjustment notion of health." In our society, men and women are trained to fulfill different social roles. For a woman to be healthy, she must adjust to the behavioral norms for her sex, even though these behaviors are less socially desirable and considered to be less healthy for the generalized competent, mature adult.

Acceptance of an adjustment notion of health places women in the position of having to decide whether to exhibit characteristics considered desirable for men and adults and have their "femininity" questioned, or to behave in the prescribed feminine manner, accept second-class adult status, and possibly live a lie to boot.

Another problem with the adustment notion lies in the conflict between the overt laws and ethics versus the real customs and mores which shape an individual's behavior. A girl who wants to become an engineer or business executive, or a boy who aspires to be a ballet dancer or a nurse, will at least encounter raised eyebrows. More likely, considerable obstacles will be put in their paths by parents, teachers, and counselors.

We are not suggesting that it is the clinicians who pose this dilemma for women. We see the judgments as merely reflecting the sex-role stereotypes and the differing valuations of these stereotypes in our society. The study does show that clinicians accept and help to perpetuate the stereotypes. Clinicians exert an influence on social standards and attitudes beyond that of other groups, not only through clinical functioning, but also out of their role as "expert" which leads to consultation to governmental and private agencies of all kinds.

It may be worthwhile for clinicians to examine their attitudes concerning sex-role stereotypes, as well as their position with respect to an adjustment notion of health. The cause of mental health may be better served if men and women are encouraged toward maximum realization of individual potential, rather than to an adjustment to existing restrictive sex roles.

The Development of a Psychiatric Training Program for Medical House Officers

THOMAS F. DWYER

There is general agreement that the physician needs additional psychiatric training. One place where he may receive this training is during his internship and residency. The Medical Service of Massachusetts General Hospital requested psychiatric teaching for its house officers, and the Psychiatric Service assigned a psychiatrist to develop a training program.

The aim is to provide the medical house officers with skills in psychological diagnosis and management that will enable them to respond to psychiatric disturbance in their patients at an early stage. There are advantages to teaching psychiatry at the level of residency training. The resident is more open to educational influences that may allow him to shift his basic approach to patients. All residents are within reach of organized psychiatric training, whereas only about 10 percent of practitioners will stay with psychiatric teaching when it is offered to them.

The training most needed for the practicing physician can be done easiest by psychiatric and medical instructors working together with the same trainees. The resident's learning of psychological principles is enhanced by the fact of his responsibility for the care and behavior of his patient. After the relevance of this kind of learning has been demonstrated, a conference devoted to psychological medicine can be added to the house officer's schedules.

Which part of the house officer's program is most suitable for psychiatric participation will vary. In the experience being reported upon, we confined the teaching to the ward service. This strategy took into account the need for the psychiatric instructor to become acquainted with the other ward personnel and to become familiar with the setting and rhythm of their work.

The daily work rounds are informal and flexible and provide an opportunity to discuss any aspect of a patient in detail. The house officers are reevaluating their patients and are open to information and opinions by the nurses and others, including the psychiatric instructor. The psychiatrist can call attention to inappropriate responses of the residents to a patient. The goal of such instruction may be to remind the resident of the human values, his own and his patient's, that are inherent in medical care.

At a weekly social service conference the psychological-social situations of all patients on the ward are reviewed. When functioning as intended, the conference is a rich educational experience, permitting an interchange of information between house officers, nurses, and social workers and the formulation of a program tailored to each patient. More rarely the conference is used mainly as a means of expediting the disposal of patients from the ward. In a situation of this kind the psychiatric instructor can intervene in a way that is useful to the patient and to the functioning of the conference as an educational institution.

After the teaching had been in effect for some months, a weekly psychiatric conference was added to the

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house officers' schedule. A patient is presented by a house officer or student, and interviewed at the conference by the psychiatric instructor; the findings from the interview plus other data are discussed regarding psychological factors affecting medical management. The purpose is to allow development of the psychological features of an individual patient and the elucidation of principles that could be applied to other patients with similar personality structures.

An unplanned function was their providing a rather sensitive measure of the house officers' fluctuating interest in psychiatric matters. This is useful. In addition, proper handling of negative responses can open up a complicated situation and allow its use for further teaching.

The range of subject matter extends from the behavioral responses of doctors, patients, and nurses to the place of psychopharmacologic agents and electroshock treatment in individuals with depression. The most critical factor is relevance to the care of the ill patient.

Teaching focused on practical (patient-oriented) issues—Psychiatrists with limited experience in liaison work often discuss material that would be interesting to other psychiatrists and that would deserve attention in long-range psychotherapy but which is irrelevant to medical management. House officers may be fascinated by the wealth of psychological data but are soon alienated since they are unable to apply it or see it leading to any useful conclusion.

Emotional responses of the doctor to the patient or illness—The house officers are reminded that the clinical detachment necessary for good judgment is more likely to be achieved if the doctor remains aware of his emotional reactions rather than pretending that they do not exist. Episodes where the emotional needs of the patient are misread because the doctor has projected his own feeling into the situation are useful to illustrate this issue. Not infrequently the resident's belief that his patient's anxiety or depression is an inevitable consequence of the illness causes the resident to miss a treatable situation.

Usefulness of personality types—It is useful to the house officers to learn to identify the personality types among psychologically normal patients and to understand how these characteristics may obstruct the course of treatment or be used by him to promote effective management.

The Psychiatric Resident

The psychiatric resident does not automatically see consultation work as relevant to his training and he may remain minimally involved. With the support and example of his psychiatric instructors, he may work with the house officers, uncovering the more treatable problems that can provide a rich learning experience. In our programs the residents were offered a weekly seminar on the psychiatric consultation.

Two points in the supervision of the psychiatric residents deserve attention. The weekly supervisory hour is not adequate for consultation work and the psychiatric instructor needs to have some time available daily for individual consultation. The second point relates to the psychiatric resident's feeling about status. Consultation exposes him to an unstructured situation that may provoke anxiety and impair his learning experience. Opportunity for discussion with his supervisor can lead the resident to discover some sociological points of interest about the environment in which he is operating and promote his learning and his effectiveness.

The quality of the written consultation can influence a teaching program, and the psychiatric residents need supervision in this area. Reports that are diffuse and rambling, full of speculative and irrelevant "dynamics," couched in psychiatric jargon, will add neither to the medical resident's handling of his patient nor to his knowledge of psychiatry. Residents should provide their supervisors with copies of their reports for the first few months.

The training of a psychiatric resident in consultation involves his unlearning of psychiatric habits. The need to elicit a history under conditions in which the interview is carried on at bedside with other persons coming and going—all within 10 to 30 minutes—can have a salubrious effect on the resident who has become used to sitting with a patient for an hour at a time and with months of hours stretching before them. Skill in making his report an effective communication requires that the resident identify with the problems of a neighboring "tribe." When this experience works well, it facilitates a capacity to communicate with all physicians and allows him to acquire a broader vision of what is psychotherapy.

The Psychiatric Instructor

It is desirable that the psychiatric instructor retain an interest in medicine and that he empathize with the tasks and problems of the practicing physician.

The underdeveloped state of psychiatry can create special problems for the teacher of psychiatry. Competent psychiatric teachers not infrequently question the value of what they are doing, at times to the point of withdrawal from the teaching. The instructor's milieu includes an audience that is rather sure of its facts or that is expecting an early removal of ambiguities. Too long an exposure to this environment without the chance to discuss matters with his psychiatric colleagues may lower the morale of the instructor and prevent him from discovering the uncertainties which exist in medicine generally.

There are unexpected benefits. Contact with a large number of patients with a variety of illnesses and backgrounds and a small number of house officers questioning the meaning of the psychiatrist's remarks, broaden the psychiatrist's experience and may stimulate him to novel approaches.

A psychiatric training program for house officers will evoke equivocal responses from the medical staff. A few physicians do well without special training in management of psychological problems. Others respond in a stereotyped manner to emotional upsets, or ignore them.

Some of the medical staff define the psychiatrist's competence as being restricted to patients with severe mental illness. These physicians conceptualize psychological health and illness as opposed polarities. Doctors who hold these convictions may feel negative toward psychiatric teaching. Another group is disturbed by psychiatric teaching because it makes emotional factors explicit in the patient and physician. Still another group will be negative or disinterested because of experience with psychiatric consultations that have been irrelevant or impractical. Although these and some other negative reactions are to be expected, their existence should not be allowed to excuse and obscure defects in the psychiatric teaching.

Positive support from the physician-in-chief is essential for the establishment of a program for medical house officers. There are occasions when the chief may sanction a psychiatric train-

ing program but his antipathy to psychiatry may be sufficiently intense that his actions and remarks will undercut the approval he has given.

The response of the house officers can be predicted in general terms. There will be one or two who will remain indifferent to the program and be untouched by it. The remaining will participate actively, utilize it fully, and demonstrate their knowledge in altered management of their patients. By the second or later year of operation there will be requests from individual house officers to spend full time on psychiatry for a month or longer. Planning for the training of such individuals and for elective periods of training for medical students should be built into the initial structure of the program.

The potential for the development of the psychiatric resident by participation in the liaison service should be emphasized. The effective psychiatric teacher of non-psychiatric physicians must reconceptualize his knowledge of psychiatric theory and practice in order to deliver information in a form that makes it possible for his colleague to understand the data and to apply them. At the same time, consultation work trains him to diagnose and prescribe for complex situations. An essential part of this training is that the psychiatric resident increases his identification with other health professionals and learns to communicate effectively with them. This experience will make them not only more effective in dealing with medical professionals in the developing community health programs but also assist them in new roles that are emerging, for example, as consultants in governmental agencies.

One among many by-products of such a training program can be the research projects that it is likely to open up. Among the more obvious are collaborative projects that include psychosomatic research and evaluation of the effects on hospitalization of the application of psychological principles to medical care. Further studies on the development of the physician's attitude toward his patients are necessary. In this period of rapid change in medicine, it seems desirable that psychiatrists with experience in liaison work take part in pilot studies in which personnel who are not M.D.'s are trained to function in the care of ill patients.

Mental Health and the Law

A Lawyer in the Counseling Center

Henry P. Kirk and Stanley W. Levy

Students frequently encounter situations requiring legal information and expertise. Highlighting this fact are the legal actions which have followed demonstrations, sit-ins, and protests on and off campus. Student need for legal sophistication also includes questions involving military draft obligations, landlord-tenant rights, personal injury suits, and civil and criminal violations. Married students need information about domestic relations or contractual matters.

Since legal questions frequently involve inter- and intrapersonal relationships, it seems appropriate to offer legal education and counseling services within the counseling center. At California State College, Los Angeles, a lawyer has been retained to work with center personnel to ameliorate the multidimensional problems encountered by students on this large, urban campus.

The primary task of the legal counselor is to inform the student of his legal rights and responsibilities. The integrity of the lawyer-client relationship is preserved, but the legal counselor does not represent the student, arrange bail, or assume an advocate position in court. His function is to provide information, help formulate a plan to resolve legal difficulties, and give needed psychological support.

A student seeking legal counseling comes to the center and visits with a regular member of the staff. After the counselor decides that it is appropriate for the student to see the legal counselor, the student completes a form, describing the nature of the problem. This information, which is confidential, is given to the lawyer before the appointment.

During the first three quarters of the academic year 1968–69, 257 male and 45 female students were interviewed by the legal counselor. A sample of 151 students was selected at random from the 302 students, and a questionnaire was mailed to them. Ninety questionnaires were returned.

Eighty-one percent felt that the information was very helpful or somewhat helpful, while 14 percent found it to be of little or no help. Ninety-two percent perceived the lawyer as genuinely interested in their problem. Other answers revealed that 58 percent would have preferred to speak directly with the lawyer; 37 percent concluded it was helpful to see a counselor first. In terms of clarifying the problem 61 percent found that filling out the information sheet was helpful. Eighty-two percent said that they were able to obtain a satisfactory appointment time and 88 percent found the half-hour session to be adequate. Thirty-two percent would not have been able to obtain legal information unless this service had been available.

Suggestions included instituting a legal information service by telephone, utilizing legal interns, adding non-Caucasian lawyers to the staff, and printing a booklet of general legal information for students.

Condensed with permission from the *Personnel and Guidance Journal*, 48(7): 575–577, 1970.

Mental Health News Digests

New Federal Drug Abuse Program

The Federal government has launched an intensive program to combat the increasing problem of drug abuse throughout the country. The program is directed by an Ad Hoc Committee on Drug Abuse, chaired by Charles B. (Bud) Wilkinson, Special Consultant to the President. Members include John E. Ingersoll, Director of the Bureau of Narcotics and Dangerous Drugs; Dr. Stanley F. Yolles, Director of the National Institute of Mental Health; and representatives of the Office of Economic Opportunity and the Departments of Defense; Health, Education, and Welfare; Labor. Objectives of the Committee are to improve existing programs and materials on drug abuse; to improve methods of making material on drug abuse available to the public; to improve coordination of efforts of departments and agencies concerned with drug abuse; and to improve upon and seek new ways that concerned groups can fight drug abuse.

Teacher training—The Office of Education will direct a $3.5 million program to train school personnel, particularly teachers, in the fundamentals of drug education. Grants will be given to States on the basis of their populations. The minimum will be $40,000 and the maximum $210,000. States will be encouraged to match their grants, but this will not be necessary. Each State will be free to spend money on training teachers as it sees fit, but the Office of Education anticipates that most States will want to use the Government's training centers that will be operated around the country.

A National Action Committee has been formed to provide leadership, technical assistance, and aid in program planning, development, monitoring, and evaluation. In April the Committee sponsored a conference in Chicago to work out details of the program with representatives from all the States. This summer those States participating in the program are sending approximately 300 teachers, counselors, administrators, students, and community leaders for training at university centers. In the fall these teams will tour their home State to train additional personnel in all local school districts, with an estimated 150,000 teachers and 75,000 students and community leaders attending the workshops. In the spring of 1971, the Committee will sponsor a series of regional conferences to evaluate the program and plan next steps.

National Clearinghouse for Drug Abuse Information—The Clearinghouse was created to give the public one central office to contact for help. Operated by the National Institute of Mental Health, it began providing services in April and should be fully operational by fall. The Clearinghouse will collect and disseminate materials and data taken from Federal programs and from private, State, and local projects. For example, it will have information on drug education curricula that are being used throughout the country. The Clearinghouse will maintain a computer data bank that will enable the Government to give much more complete answers than was possible under the former decentralized system. The Clearinghouse's address is: National Clearinghouse for Drug Abuse Information, 5454 Wisconsin Ave., Chevy Chase, Md. 20015.

Law Enforcement Assistance Administration drug program—Law En-

forcement Assistance has made available up to $10 million to large cities for programs, including drug education. Under Section 306 of the Omnibus Crime Control and Safe Streets Act of 1968, the Law Enforcement Assistance Administration may allocate 15 percent of its total appropriation for action; for fiscal year 1970 this amount is $32.5 million, of which $10 million has been set aside for 112 cities that can qualify for up to $250,000. To qualify, a city may elect one of seven categories or projects, one of which is for drug education. The Law Enforcement Assistance Administration has also set aside another $350,000 for metropolitan drug enforcement programs that must include educational expertise as a component part. Information may be obtained from the Law Enforcement Assistance Administration, Office of Law Enforcement Programs, 633 Independence Ave., N.W., Washington, D.C. 20530.

Drug abuse prevention advertising campaign—In April 1969, the National Institute of Mental Health, in cooperation with the media and the Advertising Council, Inc., launched an all-media advertising program. Facts about the dangers of abusing drugs were the basis for television and radio spot announcements, magazine and newspaper advertisements, billboards, transit cards, and posters. The Government has asked the Advertising Council to make a drug abuse program one of its major campaigns in 1970. Three Federal agencies—Departments of Defense; Health, Education, and Welfare; and Justice—have each allocated $50,000 annually to fund production costs for a wide range of new advertising messages being prepared on a nonprofit basis by Compton Advertising, Inc. The initial phase of a three-year program will emphasize prevention and will be aimed at elementary and junior high school children. Relying mainly on television, the messages are short and direct; animated cartoons are now in production. Other "commercials," advertisements, and posters, are designed to reach high school and college youth, and anti-drug messages for parents, inner city audiences and personnel in the armed services are also being developed.

Several new films are being completed. "Here's Help," a 28-minute color film, presents information on treatment and rehabilitation of drug addicts. "A Day in the Death of Donny B." documents the heroin problem in the inner city. These films will be part of a collection of educational films distributed on free loan by the National Institute of Mental Health Drug Abuse Film Collection, Distribution Branch, National Audiovisual Center (GSA), Washington, D.C. 20409.

Intensified professional training in prevention and treatment of drug abuse—The National Institute of Mental Health is accelerating its training activities in prevention, treatment, and rehabilitation with supplemental funding of $1,000,000 in fiscal year 1970. There will be four major areas for intensive training activities: training of professional and paraprofessional personnel who work or plan to work in the drug field; training of health and social service personnel to counsel those who abuse drugs; preparation of innovative training materials for teachers; and development and dissemination of materials for practicing health professionals.

Marihuana contract program—The National Institute of Mental Health marihuana research program for fiscal year 1970 will be accelerated as a result of supplemental funding of $1,000,000. The program has four major objectives: to ascertain the conse-

quences of long-term use of marihuana in human beings; to determine the effects of marihuana on driving and other skilled acts; accelerate studies to determine the pharmacological properties of marihuana, its toxicity, and effects on the physiology and behavior of animals and human beings; and to increase production and supply of marihuana in its various forms to competent investigators.

Drug Abuse Program in Kentucky

About two years ago, the commonwealth attorney of Kenton County, Kentucky, recognized the urgent need for a drug education program. The number of "drug cases" had suddenly increased, and it was felt that "prevention was better than prosecution." After a meeting with local school officials, aid and cooperation were sought from the Campbell-Kenton County Medical Society. The Society responded by financing the purchase of two educational films on drugs, and by setting up a speakers' bureau. The attorney's office produced a 20-page pamphlet, "Your Decision," giving factual information about drugs, and some 20,000 copies were distributed. Presentations have been made at many schools, churches, Parent-Teachers Associations, and many clubs and civic groups. The role of the general practitioners was felt to be especially important, since they usually participated in the community in which they practiced. (Adapted from a report by Charles Baron, M.D. in the February 1970 *Journal of the Kentucky Medical Association.*)

Mental Health News from Wisconsin

The Wisconsin Legislature has passed a bill which creates a *drug dependence program* in the Department of Health and Social Services, provides for a Drug Abuse Control Commission and a Dangerous Substance Control Council, and also provides for a major revision of State drug and narcotics laws including making use of marihuana a misdemeanor rather than a felony.

A new *drug education and referral program* has begun in Milwaukee County as a joint effort of the Mental Health Association of Milwaukee County, the Wisconsin Correctional Service, and the Mental Health Planning Committee. The program has two goals: to establish a center on drug information and to provide drug abuse education, including training for speakers and professional personnel working with young people and setting up special programs for clubs and organizations. Teams of volunteers, each with two students and one adult, are being trained to present educational programs.

Responsibility for *treatment of sex crimes offenders* has been transferred from the Division of Corrections to the Division of Mental Hygiene, both in the Department of Health and Social Services. Offenders are now committed to Central State Hospital, which has been approved as the sex crimes facility for the State, for diagnosis and treatment. The Division of Corrections will continue to supervise sex crimes offenders on probation or parole in the community.

Hospitals in four counties—Dodge, Fond du Lac, Dunn, Trempealeau—have been approved as *"direct admission treatment option"* facilities, bringing the number of such hospitals in the State to 18. This approval means that patients may receive treatment in their county hospitals whether or not their mental illness has become chronic. The hospitals, which offer psychiatric, psychological, nursing, activity therapy, and social work services, must conform to a basic level of program development and staffing.

Trempealeau County Hospital, in cooperation with the Western Wisconsin Technical Institute of LaCrosse, is giving a course in *mental health occupations* to students from several high schools. The course meets for one hour a day for a semester. After a one-week orientation on the hospital, the work of specific departments is studied both in the classroom and at the Hospital. Plans call for the course to continue as long as a need for it exists. Applications for the second semester have been so numerous that students had to be chosen on a first-come, first-served basis. (From the *Wisconsin Mental Hygiene Review*)

State Program on Alcoholism in New York

The Department of Mental Hygiene in the State of New York has started a Statewide program to train supervisory personnel to identify and help State employees who are problem drinkers. A series of training workshops are being held for supervisors. The workshops are aimed at preparing the supervisors to carry out their role in identifying the problem, interviewing the employee, and referring him to sources of help. Those directing the program emphasize that it is in no way punitive, nor is it designed to be a search for employees who drink. Rather, it is felt that all too often the families of problem drinkers can do little to help, but those in the work situation may be in a position to encourage the problem drinker voluntarily to seek help.

Company Controls for Drinking Problems

The National Industrial Conference Board has published its second study on the alcohol problem in business and industry, "Company Controls for Drinking Problems." Several hundred companies contributed information telling how they felt about the drinking problem and what they are doing about it. Many companies filled out a detailed questionnaire. Compared with the results of a survey made in 1958, the current survey showed that:

More companies called their problem with alcoholism serious enough to give them concern.

. . . the number of companies (of 50 surveyed) willing to rehire a recovered alcoholic rose from 14 to 18, and the number that said they "probably would rehire" rose from 18 to 24.

A larger number of companies reported effective alcohol control programs.

In another survey of 160 companies, the results showed that:

Management is giving increased attention to the alcohol problem.

The same, or similar, procedures should be followed if the alcohol problem occurs at the manager level as are followed at the employee level.

It is indeed difficult to train supervisors to discharge the responsibilities that devolve upon them in the operation of the typical alcohol program.

Alcoholics Anonymous is far and away the most effective single resource for helping those with drinking problems.

One section of the report describes agencies and resources available to a company needing special services. Another section gives policy statements, charts, articles from house organs, and illustrative materials that have been found useful in alcohol programs in business and industry.

Information about price of the publication, including special rates for teachers and students, may be obtained from the Information Service Division, National Industrial Conference Board, Inc., 845 Third Ave., New York, N.Y. 10022.

WHO Report on Drug Dependence

Several WHO Expert Committees have drawn attention to the dangers from abuse of hallucinogens, central nervous system stimulants, and depressants, none of which are now un-

der international control. Much of this latest report of the WHO Expert Committee on Drug Dependence is concerned with measures that might be taken to remedy this situation. It is noted that the United Nations has prepared a "Draft Protocol on Psychotropic Substances," which has been sent for comment to governments and appropriate international organizations.

On the matter of the classification, by level of control required, of drugs not under international control, the Committee agreed with the 1968 Committee report that control "must be based on two considerations: (a) the degree of risk to public health and (b) the usefulness of the drug in medical therapy." It reviewed an extensive list of drugs and using these two criteria drew up a detailed classification which appears in the report.

The report contains suggestions for dealing with preparations containing one or more controlled drugs and discusses the possibility of defining an additional group of controlled drugs to comprise "chemical precursors capable of relatively simple transformations into dependence-producing drugs." Other sections deal with the need for international control of diprenonphine and several drugs producing amphetamine-type dependence, reviews the present situation with drugs previously considered; and discusses treatment, rehabilitation, methadone maintenance, and use of specific opiate antagonists in therapy.

The report is WHO Expert Committee on Drug Dependence, Seventeenth Report, World Health Organization Technical Report Series, 1970, No. 437; (31 pages; price $1.00, 6/–, Sw.fr 3.–. In English, French, Russian, and Spanish). It may be ordered from the American Public Health Association, Inc., 1790 Broadway, New York, N.Y. 10019, or the World Health Organization, Distribution and Sales Unit, Geneva, Switzerland.

White House Conference on Children and Youth

The 1970 White House Conference on Children and Youth is scheduled for December 13–19, 1970 in Washington, D.C. National Chairman of the Conference is Stephen Hess. Joseph H. Douglass is Chairman of the Executive Committee of the Conference's National Advisory Committee and Director of the Office of Voluntary and Professional Organizations. Present plans call for the Conference to be held in two stages. The first will be the National December conference in Washington; regional conferences in Denver, Indianapolis, Omaha, Portland, Pittsburgh, and Tampa in November will precede the national conference. The second will be a Youth Conference in June 1971 with many young people throughout the country taking an active part in planning. Information about the Conference may be obtained from Stephen Hess, White House Conference on Children and Youth, The White House, Washington, D.C.

Conference on Aging

"Roles for Older People—Prospects for the 70's" is the theme of The University of Michigan's 23d Annual Conference on Aging, August 12–14, 1970.

The broadest possible participation is being encouraged by older people who will present the challenge to the conference and by leaders from social welfare organizations, government, educational institutions, industry, labor, community planning agencies, religious organizations, and many kinds of professional and technical groups who will share responsibility for identifying the major issues in ag-

ing to be resolved in the 1970's and discussing mechanisms for shaping a better life for America's older people.

As a special feature, the 35th anniversary of the passage of the Social Security Act will be celebrated by distinguished national leaders who will review the beginnings of social security in this country, assess its achievements, and discuss its promise for the future of America's older people.

For information write to Woodrow W. Hunter, Acting Co-Director, Institute of Gerontology, 1021 E. Huron Street, Ann Arbor, Michigan 48104.

Psychotherapy and the Dual Research Tradition

Much of the misunderstanding in psychiatry concerning the roles of the clinician and the researcher stems from the similar, yet different, approaches of the two disciplines, according to a new report entitled *Psychotherapy and the Dual Research Tradition*. The report was formulated by the Group for the Advancement of Psychiatry's Committee on Therapy.

The report starts by giving a clinician's view of psychotherapy, describes the participants, the aims and assumptions of each, the structure of the relationship, the setting, and the compact. It proposes a set of reciprocal features, or polarities that enter into the process of therapy; trusting-mistrusting; gratifying-frustrating; revealing-concealing; encouraging fantasy-testing reality; reliving-new experiencing; regressing-progressing.

A brief historical sketch is given of the dual tradition that runs through much of research. It describes the variety of efforts to study strengths and weaknesses. The naturalistic approach is also described, along with its strengths and weaknesses.

The final section moves toward an integrated view of psychotherapy and research.

Copies of *Psychotherapy and the Dual Research Tradition,* GAP Publication No. 73, may be obtained for $1.50 each from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, N.Y. 10016.

Booklet on LSD

LSD–25, Layman's Guide to the Pharmacology, Physiology, Psychology, and Sociology of LSD is the title of a recent 36-page pamphlet issued by the Bureau of Narcotics and Dangerous Drugs of the Department of Justice. Copies may be obtained for $1.00 from the Superintendent of Documents, Government Printing Office.

New Publications on Juvenile Delinquency

Volunteer Programs in Courts: Collected Papers on Productive Programs (268 pages) offers court systems a series of easy-to-read papers detailing major program areas in utilizing volunteers in court probation programs.

Delinquency Today: A Guide for Community Action (22 pages) presents an overview of the problems and concepts of delinquency, past and present, and offers a suggested blueprint of community programs to deal with the problem today.

Single copies of both publications may be obtained gratis from the Information Office, Office of Juvenile Delinquency and Youth Development, 330 C St., S.W., Room 1427 South, Washington, D.C. 20201.

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DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE OF MENTAL HEALTH
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